MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8438

CERTIFICATE OF DEATH

08432

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clements
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Infant — Middle: Boy — Last: Armstrong

4. DATE OF DEATH: Month: July — Day: 8 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 7, 1961

9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months: Days: 1 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Clements, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert E. Armstrong

14. MOTHER'S MAIDEN NAME: Margie A. Herbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert E. Armstrong — Address: Clements, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable extra cranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
760.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prematurity

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ___ 19___ to ___ 19___, that (I) (we) last saw the deceased alive on ___ 19___ and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Roy Guyther M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 7/8/61

22c. PHYSICIAN'S NAME (Type): J. Roy Guyther, MD

22d. ADDRESS: Mechanicsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/8/61

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town, or county) (State): Morganza, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: C. B. Robinson — ADDRESS: C. B. Robinson - Leonardtown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 12 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Mattingly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

4200204 XVI

1

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8439 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08433

1. PLACE OF DEATH

a. COUNTY: St. Marys — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chaptico

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: St. Marys

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mechanicsville

d. STREET ADDRESS: / Rural

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Noah — Middle: C. — Last: Byler

4. DATE OF DEATH: Month: July — Day: 25 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Dec. 18, 1946

9. AGE (In years last birthday): 14 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm labor

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Chris E. Byler

14. MOTHER'S MAIDEN NAME: Sarah Shrock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no ----

16. SOCIAL SECURITY NO.: ------

17. INFORMANT Address: Chris E. Byler - Mechanicsville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): DROWNING — INTERVAL BETWEEN ONSET AND DEATH: IMMED

DUE TO (b):

Conditions, if any, which gave rise to immedieta cause (a), stating the underlying cause last. DUE TO (c):

924.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): WADED INTO POND OVER HEAD - COULD NOT SWIM.

20c. TIME OF INJURY Hour: 5:30 p.m. Month, Day, Year: 7-25 1961

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): FARM POND

20f. (City or town): CHAPTICO (County): STMARY MD (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Wm D Boyd M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Wm. D. Boyd, MD — Leonardtown, Md. — DATE SIGNED: 7/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/28/61

22c. NAME OF CEMETERY OR CREMATORY: Amish Cemetery

22d. LOCATION (City, town, or country) (State): Mechanicsville, Md.

23. FUNERAL DIRECTOR ADDRESS: C.E. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8440

CERTIFICATE OF DEATH

08434

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 20hrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: 28 Roosevelt Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Effie; Last: Campbell

4. DATE OF DEATH: Month: July; Day: 28; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 24, 1918

9. AGE (In years last birthday): 42 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Fenwick

14. MOTHER'S MAIDEN NAME: Margaret Barber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Agnes Louise Chase — Address: 28 Roosevelt Ave. Lexington Pk Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Hypertensive Encephalopathy — 3 days
DUE TO (c): A S C V D — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from 5/1/61 19 to 7/28 19 61, that (I) (we) last saw the deceased alive on 7/28 19 61, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Jas. P. Jarboe M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): James P. Jarboe M.D.

22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/31/61

23c. NAME OF CEMETERY OR CREMATORY: Our Lady's Chapel

23d. LOCATION (City, town, or county) (State): Leonardtown Md

24. FUNERAL DIRECTOR'S SIGNATURE: W. Clarke Mattingley

ADDRESS: Leonardtown, Maryland

25a. RECD BY REGISTRAR DATE: AUG 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08435

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Piney Point
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Piney Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print): First: John — Middle: Lawson — Last: Clark

4. DATE OF DEATH: Month: July — Day: 2, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 14, 1892

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Caroline County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ???

14. MOTHER'S MAIDEN NAME: Mattie Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — W W 1

16. SOCIAL SECURITY NO.: 577-14-1175

17. INFORMANT — Address: Mrs Grace L. Marshall Rt.1 Box 139 Woodford, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd MD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): William D. Boyd M.D.

Address (Street, city, town, or county):

DATE SIGNED: 7/3/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 6,1961

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country): Arlington, (State): Va.

23. FUNERAL DIRECTOR — ADDRESS: W.Clarke Mattingley Leonardtown, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kimes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if no delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 22d, Bilm G292 8/15/61 iwk

09537

1. PLACE OF DEATH
a. COUNTY — S. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) — Rural Maddox
c. LENGTH OF STAY IN Ib — 24 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE — Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) — Falls Church
d. STREET ADDRESS — 352 Peace Valley Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

8 2x-3

3. NAME OF DECEASED (Type or print) — First: Roland — Middle: Richard — Last: Denney

4. DATE OF DEATH — Month: July — Day: 29, — Year: 1961

5. SEX — Male

6. COLOR OR RACE — Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH — Aug. 22, 1905

9. AGE (In years last birthday) — 55 yrs.
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — Church Layman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? — U.S.A.

13. FATHER'S NAME — Anthony Denney

14. MOTHER'S MAIDEN NAME — Cora Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) — No

16. SOCIAL SECURITY NO.

17. INFORMANT — Address — Madge A. Denney, 352 Peace Valley Lane Falls Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Drowning
DUE TO
(c)

929.8

INTERVAL BETWEEN ONSET AND DEATH — Immed.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) — Attempted to swim ashore from small boat

20c. TIME OF INJURY — Hour: 1.45 p.m. — Month, Day, Year: 7.29 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — Wicomico River

20f. (City or town) — Chaptico (County) — St.Mary's (State) — Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE — William D Boyd M.D.

EXAMINER'S NAME (Type) — William D. Boyd M.D.

Address (Street, city, town, or county)

DATE SIGNED — 7.30.61.

22a. BURIAL, CREMATION, REMOVAL (Specify) — Burial

22b. DATE THEREOF — Aug. 2, 1961

22c. NAME OF CEMETERY OR CREMATORY — (2) Bts Ch. Cemetery

22d. LOCATION (City, town, or country) (State) — Falls Church, Fairfax Co. Va.

23. FUNERAL DIRECTOR — ADDRESS — Walter E. Hunter 2512 Sheridan Rd. S.E. Wash. D.C.

24a. REC'D BY REGISTRAR — DATE AUG 10 '61

24b. REGISTRAR'S SIGNATURE — Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08436

1. PLACE OF DEATH
a. COUNTY: St. Marys
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chaptico
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mechanicsville
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Daniel; Middle: J.; Last: Esh

4. DATE OF DEATH: Month: July; Day: 25; Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 26, 1936

9. AGE (In years last birthday): 24 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm tenent

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. Esh

14. MOTHER'S MAIDEN NAME: Susie S. Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): -----

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: John F. Esh -Mechanicsville, Md.
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DROWNING
DUE TO (b):
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: IMMED

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): ATTEMPTED TO RESCUE FRIEND

20c. TIME OF INJURY: Hour a.m. 5:30 p.m. Month, Day, Year: 7-25 1961

20d. INJURY OCCURRED: While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): FARM ROAD

20f. (City or town): CHAPTICO (County): STMARYS (State): MD

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

SIGNATURE: Wm D Boyd M.D.

EXAMINER'S NAME (Type): Wm. D. Boyd, MD

Address (Street, city, town, or county): Leonardtown, Md.

DATE SIGNED: 7/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/27/61

22c. NAME OF CEMETERY OR CREMATORY: Amish Cemetery

22d. LOCATION (City, town, or country): Mechanicsville, Md. (State):

23. FUNERAL DIRECTOR: P.B. Robinson

ADDRESS: P.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR: DATE: JUL 31 '61

24b. REGISTRAR'S SIGNATURE: Clarence E. Krause

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68437

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): California
c. LENGTH OF STAY IN 1b: 1 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): California
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle POPKEN — Last KAYIAN

4. DATE OF DEATH: Month July — Day 21 — Year 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 3, 1903

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): self-employed

10b. KIND OF BUSINESS OR INDUSTRY: Laundromat

11. BIRTHPLACE (State or foreign country): Bridgeport, Conn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Artin Kayian

14. MOTHER'S MAIDEN NAME: Mary Krikorian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO. (If yes give were or dates of service): ----- / ------

17. INFORMANT — Address: Rose C. Jernigan - California, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Infarct — INTERVAL BETWEEN ONSET AND DEATH: IMMED
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd MD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type): Wm. D. Boyd, MD

Address (Street, city, town, or country): Leonardtown, Md.

7/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/24/61

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: Joseph Gawler's Sons Inc.

ADDRESS: 1756 Pa. Ave. NW Washington, DC

REC'D BY REGISTRAR DATE: JUL 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

Film 292 8-11-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08438

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tall Timber
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X California
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle AUBREY — Last MAYOR
4. DATE OF DEATH: Month July — Day 24, — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/11/30
9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Automobile
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Leonard Mayor
14. MOTHER'S MAIDEN NAME: Myrtle E. Ridgell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Korea
16. SOCIAL SECURITY NO.: 217 34 2274
17. INFORMANT — Address: J. Leonard Mayor - Leonardtown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Drowning - Found drowned - with massive aspiration

850 X ~~XXXXX~~ of stomach content

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): ____ (c): ____

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute alcoholism

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Apparently fell overboard from moving boat
20c. TIME OF INJURY — Hour: ? a.m. p.m. — Month, Day, Year: 7/23/ 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River
20f. (City or town): Tall Timber, St. Mary's, Md. — (County): ____ — (State): ____

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 7/24/61

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/26/61
22c. NAME OF CEMETERY OR CREMATORY: Holy Face Cemetery
22d. LOCATION (City, town, or country): Great Mills, Md. — (State): ____

23. FUNERAL DIRECTOR — ADDRESS: F. B. Robinson - Leonardtown, Md.
24a. REC'D BY REGISTRAR — DATE: Aug 2 1961
24b. REGISTRAR'S SIGNATURE: Arthur J. Lewis

Aug. 11, 1961

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8446 — 08439

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Mechanicsville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Marys Hospital

d. STREET ADDRESS: Rural

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Godfrey — Last: Reed

4. DATE OF DEATH: Month: July — Day: 8 — Year: 19 61

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: August 9, 1884

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm tenent

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Reed

14. MOTHER'S MAIDEN NAME: Jane P. Jordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Joseph R. Reed - Mechanicsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH:

200.1

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Lymphosarcoma — months

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to 7/8, 1961, that (I) (we) last saw the deceased alive on 7/8, 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James P. Jarboe M.D. — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22b. DATE SIGNED: 7/8/61

22c. PHYSICIAN'S NAME (Type): JAMES P. JARBOE, MD

22d. ADDRESS: Great Mills, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/10/61

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town, or county) (State): Morganza, Md.

24. UNDERTAKER'S SIGNATURE: P. B. Robinson

ADDRESS: P. B. Robinson - Leonardtown, Md.

25a. REC'D BY REGISTRAR — DATE: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: C. Alvin L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8447

CERTIFICATE OF DEATH

9P440

1. PLACE OF DEATH
a. COUNTY: St. Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Great Mills,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Ann; Middle: Elizabeth; Last: Russell

4. DATE OF DEATH: Month: July; Day: 6, Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 13, 1879

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James N. Pilkerton

14. MOTHER'S MAIDEN NAME: Mary Louise Abell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Theodore D. Russell Jr. Address: Great Mills, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia
DUE TO (b): Decubitus Ulcer
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: hrs. month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of hip

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/?/61 to 7/6/61, that (I) (we) last saw the deceased alive on 7/6/61, and that death occured at [illegible] P.M., from the causes and on the date stated above.

22a. SIGNATURE: James P. Jarboe

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 7/9/61

22c. PHYSICIAN'S NAME (Type): James P. Jarboe M.D.

22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/10/61

23c. NAME OF CEMETERY OR CREMATORY: Holy Face

23d. LOCATION (City, town or county): Great Mills, (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 11 '61

25b. REGISTRAR'S SIGNATURE: Clarence L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8448 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08441

1. **PLACE OF DEATH**
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X [redacted] Leonardtown
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bernice — Middle: Audrey — Last: Shade

4. **DATE OF DEATH**: Month: 7 — Day: 26 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 29, 1955

9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Shade

14. MOTHER'S MAIDEN NAME: Helen Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO.

17. INFORMANT — Address: Helen M. Shade Leonardtown, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Waterhouse-Friderichsen's Syndrome — 037.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt, Jr. M.D.

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED: July 27, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/29/61

22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart

22d. LOCATION (City, town, or country) (State): Bushwood, Maryland

23. FUNERAL DIRECTOR — ADDRESS: W.Clarke Mattingley Leonardtown, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 2 '61

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8449 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08442

1. PLACE OF DEATH
a. COUNTY: St. Marys
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlotte Hall
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JIMMY Middle - Last STREET

4. DATE OF DEATH: Month July Day 9 Year 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1936

9. AGE (In years last birthday): 25 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Sawmill

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kane Street (dec)

14. MOTHER'S MAIDEN NAME: Belle Whitehead (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: -----

17. INFORMANT Address: 411 56 1364 Arnold Street - Charlotte Hall, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GUN Shot — INTERVAL BETWEEN ONSET AND DEATH: 25 Hr
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot By His Brother After Argument

20c. TIME OF INJURY Hour 10:00 p.m. Month, Day, Year 7-8 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Saw Mill

20f. (City or town) Mechanicsville (County) St Marys (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd MD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MED.CAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/10/61

EXAMINER'S NAME (Type): Wm. D. Boyd, MD

Address (Street, city, town, or county): Leonardtown, Md.

22a. METHOD OF DISPOSITION: Removal & Burial

22b. DATE THEREOF: 7/11/61

22c. NAME OF CEMETERY OR CREMATORY: Family Cemetery

22d. LOCATION (City, town, or country) (State): Hampton, Tennessee

23. FUNERAL DIRECTOR ADDRESS: P.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 12 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to [redacted] 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

55443

1. PLACE OF DEATH
a. COUNTY: St. Mary's — 8450
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Park Hall
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hills Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hollywood
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): James Henry Toney (First Middle Last)

4. DATE OF DEATH: July 14, 1961 (Month Day Year)

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Aug. ?, 1876

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harvey M. Toney

14. MOTHER'S MAIDEN NAME: Elizabeth Holand

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: William H. Toney
Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Ast~~ Cerebral Vascular accident
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 days / 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(e)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19...., to ....., 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at .....M, from the causes and on the date stated above.

22. SIGNATURE: Ernest D. Rehm M.D.

22b. DATE SIGNED: 7/17/61

22c. PHYSICIAN'S NAME (Type): Ernest Rehm M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/17/61

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

23d. LOCATION (City, town or county) (State): Hollywood, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: W. Clarke Mattingley

ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 18 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08444

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: St. Mary's
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   c. LENGTH OF STAY IN 1b: 5 Min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Drayden
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry; Middle Alexander; Last Whalen

4. DATE OF DEATH: Month July; Day 23; Year 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1933

9. AGE (In years last birthday): 28 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): day laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Raymond Whalen

14. MOTHER'S MAIDEN NAME: Helen Medora Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
    (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: 214-30-2425

17. INFORMANT: Carrie A. Whalen Address: Drayden, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractures Skull — INTERVAL BETWEEN ONSET AND DEATH: 15 mins.

823X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Lost control of car & ran off road.

20c. TIME OF INJURY: Hour 6:35 p.m. Month, Day, Year 7-23 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route #5 - 1 Mi-So - LEONARDTOWN (City or town) ST MARYS (County) MD (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William D. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): William D. Boyd M. D.

Address (Street, city, town, or county):

DATE SIGNED: 7/24/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/26/61

22c. NAME OF CEMETERY OR CREMATORY: St. Mark's

22d. LOCATION (City, town, or country) (State): Valley Lee, Maryland

23. FUNERAL DIRECTOR ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

24c. REC'D BY REGISTRAR DATE: JUL 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Hance

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8452 — 08445

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown,
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Loveville,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Somerville — Last: Young

4. DATE OF DEATH: Month: July — Day: 31, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 9, 1896

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Somerville

14. MOTHER'S MAIDEN NAME: Jennie Holley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: 215-26-0212

17. INFORMANT — Address: James A. Young Loveville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stroke (Cerebral Vas. Accident)
DUE TO (b): hypertension
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331 X

INTERVAL BETWEEN ONSET AND DEATH: 1d

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 17, 1961 to July 31, 1961, that (I) (we) last saw the deceased alive on July 31 19 61, and that death occured at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Leon Berube M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Leon Berube M.D.

22d. ADDRESS: Mechanicsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/3/61

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's

23d. LOCATION (City, town or county) (State): Morganza, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 4 '61

25b. REGISTRAR'S SIGNATURE: Cirilus L. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60